State of Connecticut
Department of Public Health
Bureau of Health Care Systems
Division of Health Systems Regulation

In Re: Lexington Highgreen Holding, Inc.
Farmington, Connecticut

d/b/a Greenwood Health Center
5 Greenwood Street
Hartford, CT 06106

CONSENT ORDER

WHEREAS, Lexington Highgreen Holding, Inc. of Farmington, Connecticut (hereinafter "Licensee") previously was issued Licensee No. 2195-C to operate a Chronic and Convalescent Nursing Home known as Greenwood Health Center (hereinafter "the Facility") by the Connecticut Department of Public Health (hereinafter "Department"); and,

WHEREAS, the Department's Division of Health Systems Regulation conducted inspections of the Facility which were initiated on February 26, 2003 and concluded on July 9, 2003 in order to determine the Licensee's compliance with the provisions of the Regulations of Connecticut State Agencies; and,

WHEREAS, during the course of the aforementioned inspections, violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies were identified (hereinafter "Violations"). These Violations were detailed in a violation letter sent to the Facility on July 30, 2003 (Exhibit A); and,

WHEREAS, the Licensee denies the allegations made by the Department in Exhibit A; and

WHEREAS, the Department issued a Statement of Charges, which incorporates the Violations, against the Licensee on December 5, 2003, and the Licensee filed its Answer and Affirmative Defenses to such Statement of Charges on December 23, 2003, and

WHEREAS, the Licensee is willing to enter into this Consent Order in order to settle and resolve the Violations and Statement of Charges and to avoid the expense and inconvenience of future proceedings.

NOW THEREFORE, the Department acting herein by and through Marianne L Horn, its Director of the Division of Health Systems Regulation, the Licensee, acting herein by and through Attorney Abe Backenroth, its bankruptcy counsel, hereby stipulate and agree as follows:

1. The Licensee agrees to the following:
   a. Within six (6) months of the effective date of this Consent Order, the Licensee and its officers and directors, who were serving in said capacity as of February 26, 2003 (the "officers and directors"), will relinquish all ownership in Connecticut healthcare institutions as defined in Connecticut General Statutes § 19a-490; and
   b. The Licensee and its officers and directors shall never own, operate, be an employee of, manage or perform administrative functions in any healthcare facility licensed by the Department or any other form or type of health care provider in the State of Connecticut or which serves the residents of the State of Connecticut in Connecticut. The Licensee and its officers and directors shall never have an independent contractor relationship with a health care institution as defined in Connecticut General Statutes § 19a-490 or any other form or type of health care provider in the State of Connecticut or which serves the residents of the State of Connecticut in Connecticut. In addition, the Licensee and its officers and directors shall never serve on the Governing Board of a health care institution as defined in Connecticut General Statutes § 19a-490 or any other form or type of health care provider in the State of Connecticut or which serves the residents of the State of Connecticut in Connecticut.

2. Licensee has presented this Consent Order to its officers and directors, and said officers and directors have provided to the Licensee a written acknowledgement stating that they have reviewed and understand the terms of the Consent Order as it relates to them.
3. It is expressly agreed and understood that this Consent Order shall not constitute an admission of any improper or illegal conduct by Licensee and/or its officers and directors, and Licensee and/or its officers and directors deny any allegations of improper or illegal conduct, if any, raised by the Department.
4. It is expressly understood that the Department is required and will file an Adverse Action Report with the Healthcare and Integrity Protection Database (HIPDB) in the name of the Facility and not in the names of the officers and directors, except to the extent that it is necessary to provide the names and titles of principal officers and owners as mandated by the HIPDB Adverse Action Report form.
5. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
6. All inquiries relative to this Consent Order shall be directed to:

Maureen Klett, R.N.,
Supervising Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capital Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

7. The Licensee agrees that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Consent Order or of any statutory regulatory requirements which may have occurred on or after July 30, 2003. Such legal remedies for violations of this Consent Order or of any statutory or regulatory requirements shall include, but not be limited to, all options for the issuance of citations and/or the

imposition of civil penalties calculated and assessed in accordance with section 19a-524 et seq. of the Connecticut General Statutes, or any other administrative and judicial relief provided by law.

8. This Consent Order with Exhibit A may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue or in which compliance with state or federal statutes or regulations is at issue.
9. The Licensee has consulted with an attorney prior to signing this Consent Order.
10. This Consent Order is a public document.
11. The Licensee is responsible for any costs associated with compliance with this Consent Order.
12. This Consent Order embodies the entire agreement of the parties with respect to the subject matter involved herein. All previous communications and agreements between the parties, whether oral or written, are superseded unless expressly incorporated herein or made a part hereof.

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective immediately upon the signature of a representative of the Department.

LEXINGTON HIGHGREEN HOLDING, INC.
FARMINGTON, CONNECTICUT

By: _____
Abe Backenroth, Esq.
Bankruptcy Counsel for the Licensee
Authorized Representative

Personally appeared the above named Abe Backenroth on May 4, 2004 and made oath to the truth of the statements contained herein.

My Commission Expires: _____

_____
Notary Public
~~Commissioner of the Superior Court~~

MARK A. FRANKEL
Notary Public, State of New York
No. 41-4915883
Qualified in Nassau County
Commission Expires November 30, 2005

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

May 17th 2004
Date

By: _____
Marianne I. Horn
Director, Division of Health Systems Regulation

ACKNOWLEDGEMENT OF CONSENT ORDER REGARDING LEXINGTON HIGHGREEN HOLDING, INC. D/B/A GREENWOOD HEALTH CENTER

I, OSCAR LICHTMAN, who was serving in the capacity of an officer or director for Lexington Highgreen Holding, Inc. ("Lexington") on February 26, 2003, have received a copy of the Consent Order agreed to by Lexington and the Connecticut Department of Public Health and approved by the Bankruptcy Court on _____, 2004 (the "Consent Order").

I have reviewed the Consent Order and understand and agree to the terms of the Consent Order as such terms relate to me as an individual who served Lexington in the above-mentioned capacity. I understand that such terms are binding on me as an individual.

Oscar Lichtman
[Print Name]

Personally appeared the above named OSCAR Lichtman on May 14, 2004 and made oath to the truth of the statements contained herein.

My Commission Expires: _____

Notary Public
Commissioner of the Superior Court

\[illegible]\2001447\6.1

JACOB N. GELFAND
NOTARY PUBLIC, State of New York
No. 02GE5[illegible]
Qualified in Queens County
Commission Expires January 31, 2005

EXHIBIT A

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

July 30, 2003

Veronica Cretella, Administrator
Greenwood Health Center
5 Greenwood Street
Hartford, CT 06106

Dear Ms. Cretella:

Unannounced visits were made to Greenwood Health Center on February 26, 27, 28, March 1, 5, 6, 10 and May 9, 2003 by representatives of the Division of Health Systems Regulation for the purpose of conducting an investigation with additional information received through July 9, 2003.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for August 13, 2003 at 10:00 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Janet M. Williams, JCN

Janet M. Williams, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JMW:zbj

cc: Director of Nurses
Medical Director
President
Daniel Shapiro, AAG
Arnold Menchel, AAG
John DeMattia, SAO
#2003-0215
vlgreenhcc.doc

Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS #_____
P.O. Box 340308 Hartford, CT 06134

DATES OF VISIT: February 26, 27, 28, March 1, 5, 6, 10 and May 9, 2003.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Management, supervision and oversight of staff was lacking as evidenced by the findings contained within this violation letter.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1) and/or (f) Administration (3)(A) and/or (f) Administrator (3)(F) and/or (j) Director of Nurses (2).

2. Based on clinical record reviews, observations and interviews for eight (8) of eight (8) sampled residents who were permitted to smoke unsupervised (Residents #80, #87, #110, #115, #118, #128, #133 and #134), the facility failed to accurately assess and/or reassess the residents' ability to smoke unsupervised.
   a. Resident #87 had diagnoses of COPD, dementia and schizophrenia. The assessment of 10/09/02 identified moderately impaired cognitive skills with poor decisions, cues and supervision required. The smoking evaluation dated 1/6/03 identified resident required a smoking apron and designated Resident #87 as an unsupervised smoker. The Resident Care Plan (RCP) did not address resident's smoking, however, an interdisciplinary note of 1/13/03 identified the resident smoked independently with a smoking apron. Observation on 2/26/03 at 12 Noon revealed Resident #87 seated in her room in wheelchair with a rollbar. A smoking apron was covering the resident. The resident was unable to answer questions appropriately and had no cigarettes but the resident had a cigarette lighter in her wallet. LPN #1 stated resident bought cigarettes off of another resident and smoked unsupervised on the patio. Despite the assessment of the need for supervision, the resident was designated as an unsupervised smoker.
   b. Resident #80 most current assessment dated 12/24/02 identified cognitive skills for decision making as poor, cuing and supervision required. Diagnosis included COPD and dementia. Review of the smoking evaluation identified the resident could smoke unsupervised. The RCP of 3/8/03 did not address smoking and there was no identification of Resident #80 selling cigarettes to other residents as reported by staff. Observation of the resident on 2/26/03 identified the resident had cigarettes and lighter in his front left pocket. LPN #1 stated on 2/26/03 Resident #80 carried his own cigarettes and lighter and was independent in smoking and that the resident bought and sold cigarettes for other residents to earn money. Despite the assessment for the need for supervision, the resident was designated as an unsupervised smoker.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

c. Resident #110 had diagnoses that included seizure disorder, dementia and traumatic brain injury. The assessment of 12/23/02 identified moderately impaired in decision making, supervision required. The admission smoking evaluation identified resident as a non smoker. The RCP of 12/18/02 did not address smoking. There were no additional smoking assessments per facility policy. The RCP on 2/24/03 identified unsafe smoking and smoking in room as a problem. Interventions included smoking materials to be kept by nursing, remind resident of policy and danger of smoking in undesignated areas. Observations on 2/27/03 revealed Resident #110 in his room with a lighter in his possession. Resident stated he smoked outside and got cigarettes from other residents. On 2/26/03 LPN #2 identified the resident as an independent smoker who had been transferred to unit 7 on 1/27/03. Despite the assessment for the need for supervision, the resident was designated as independent and smoked unsupervised.

d. Resident #115 diagnoses included, in part, alcohol abuse and seizure disorder. The 10/21/02 hospital discharge summary identified that the resident smokes 5 cigarettes per day. The nursing admission assessment dated 10/21/02 identified the resident as a smoker. An admission assessment dated 10/31/02 and/or the 1/24/03 quarterly assessment identified a traumatic brain injury. Review of the resident's clinical record failed to provide evidence that the resident was assessed for smoking abilities. Observation on 2/27/03 at approximately 12:30 PM identified the resident was outside with approximately 8 other residents all of whom were smoking. No staff were present in the smoking area. Interview with the RCP Coordinator on 2/27/03 at 12:45 PM identified she was unable to explain why the resident did not have a smoking assessment.

e. Resident #118 was admitted to the facility on 8/28/01 with a diagnosis inclusive of schizo-affective disorder. Review of the smoking reassessment dated 11/7/02 identified that Resident #118 was classified as an independent smoker. Review of the nurse's note dated 1/5/03 identified that Resident #118 was found at 3:30 AM smoking inside the facility next to a garbage receptacle. Review of the smoking reassessment form identified that subsequent to the 1/5/03 smoking incident, the resident was not reassessed for smoking abilities. Review of the RCP dated 1/6/03 identified that observations for inappropriate smoking behavior were to be instituted. Review of the clinical record on 2/26/03 failed to provide evidence that monitoring of inappropriate smoking behavior was conducted. Review of the NA assignment failed to provide information relative to monitoring of the

resident for smoking in non designated areas. In an interview with LPN #2 on 2/26/03 she could not say why the record lacked documentation of the monitoring and the NA assignment failed to address the monitoring of the resident's smoking.

f. Resident #128 had a court appointed conservator of person. The resident's diagnoses included dementia, schizophrenia and mental retardation. The assessment of 10/31/02 identified long and short term memory problems, moderately impaired decision making, cues/supervision required. The smoking evaluation tool dated 3/1/98 failed to reflect the designation for smoking. Smoking reassessments from 5/2/00 through 1/29/03 indicated resident was designated as being able to smoke unsupervised. The RCP on 11/14/02 identified resident as an independent smoker with a goal to smoke in designated areas only. Interventions included to evaluate as needed, review assessment as needed, smoking apron as needed. The RCP failed to identify discipline responsible to implement the interventions. The NA assignment did not reflect the need to monitor the resident for non-compliance and/or that resident was a smoker. LPN #2 identified resident as able to smoke unsupervised.

g. Resident #133 diagnoses included schizophrenia and anxiety. A smoking evaluation dated 7/13/02 identified the resident was not oriented to place or time. A 10/3/02 quarterly assessment identified moderately impaired cognition with short and long term memory problems. It also identified mental function that varies over the course of the day. A smoking reassessment dated 10/10/02 identified the resident was a candidate for independent smoking. The behavioral/intervention monthly flow record and the nurses notes dated 12/1/02 at 3:00 AM identified the resident was found smoking in the bathroom. The 12/1/02, 3:00 AM nurses note further identified the resident was advised regarding unsafe smoking or that he may lose possession of his cigarettes. The record review failed to provide evidence that the resident was reassessed for smoking safety after the resident was found smoking in the bathroom.

h. Resident #134 was admitted to the facility on 10/7/02 with diagnoses inclusive of schizophrenia and Non-Hodgkins Lymphoma. Review of the clinical record identified a psychiatric evaluation dated 11/19/02 that indicated Resident #134 continued to exhibit poor insight. Review of the smoking evaluation completed on 12/19/02 identified that although Resident #134 did not demonstrate compliance with smoking in designated areas and appropriate disposal of ashes, he was classified as an independent smoker. Review of

nurses notes dated 12/31/02 identified that Resident #134 was found smoking in his room on various occasions. The note further identified that after reminders were provided the inappropriate smoking behavior continued. Review of clinical record failed to provide evidence that a smoking assessment form was completed subsequent to the 12/31/02 smoking incident. Review of the Resident Care Plan (RCP) dated 12/31/02 identified that cigarettes and lighter were to be provided only during scheduled smoking times. The RCP further identified that the resident's room was to be checked frequently for smoking materials. Review of the clinical record on 2/26/03 failed to provide documentation that the interventions were implemented. Review of the Nurse Aide (NA) assignment failed to identify any documentation related to smoking. In an interview with LPN #2 on 2/26/03 she was unable to explain why the NA assignment did not reflect the resident's smoking abilities/safety issues and she further stated that Resident #134 was classified as an independent smoker.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

3. Based on record review and interviews, the facility failed to develop comprehensive care plans for two (2) of two (2) residents with a mental and/or physical impairment. The findings include:
   a. Resident #1 was admitted to the facility on 2/5/03 following discharge from a local hospital. The resident had been admitted to the local hospital after the resident had demonstrated suicidal gestures, which consisted of swallowing a ring and burning self with a cigarette. The RCP of 2/5/03 and 2/6/03 identified a problem in the area of depression, which was associated with harming self. The facility failed to identify specific interventions to address the problem, but instead identified non-specific interventions, which consisted of medicate as ordered, encourage out of room activity, encourage family involvement and monitor for signs and symptoms of depression. The latter intervention was also non-specific as to what signs and symptoms were to be observed. A review of the medical record revealed that on 2/10/03 the resident was transferred to a local hospital for increased depression. Although a behavioral monitoring flow sheet had been instituted for this resident, documentation was lacking to reflect any signs and symptoms of depression

had been observed for this resident on the day of transfer to the hospital. Interview with the charge nurse for Unit 8 revealed that she had been the nurse responsible for sending the resident to the hospital for the evaluation on 2/10/03. The resident had been depressed over the weekend and was crying constantly. The charge nurse was not able to offer a rationale as to why this information had not been incorporated into the medical record. She was also not able to identify RCP interventions which had been implemented relative to the resident's depression and/or history of self-harm.

b. Resident #26's MDS of 1/15/03 identified limitation with regards to range of motion in both hands, which also included partial loss of voluntary movement. Diagnoses included paraplegia. An occupational therapy screening document dated 10/14/02, identified impairment in upper extremity range of motion. A smoking evaluation dated 10/17/02 identified that the resident was an independent smoker. The RCP of 2/23/03 identified the resident as an independent smoker. Interventions which were identified on the RCP to address the resident's smoking designation, were generic and non-specific to the resident's demonstrated impairment in both upper extremities. Although one of the interventions identified that a smoking apron was to be provided as needed, documentation was lacking to reflect that this was done. Interview with the DNS on 3/10/03 identified that interventions relative to smoking were generically written for the entire smoking population, and were to be individualized following the smoking evaluation and that documentation was lacking to reflect that the resident was monitored for the need to institute the identified interventions.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

4. Based on record review and interviews, the facility failed to review and revise a comprehensive care plan for Resident #1.
   a. Resident #1 was admitted to the facility on 2/5/03 with diagnoses, which included multiple sclerosis and depression. The resident assessment data collection form dated 2/5/03 identified the resident's functional status as requiring assistance with activities of daily living. Comprehension was described as slow and identified the resident was disoriented to place. Personal habits included smoking. An occupational therapy plan for treatment identified the resident's fine motor coordination as impaired. A smoking

evaluation which was undated, identified that the resident was not oriented to place, rationale, was described as "remains candidate" and designation was left blank. The RCP of 2/6/03 identified a problem or concern of "independent smoker." Documentation in the medical record revealed that on 2/9/03 the resident went to the patio for a cigarette and after smoking suffered a grand mal seizure. Interview with LPN #6 revealed that it was thought that smoking triggered the grand mal seizure experienced by the resident. Upon return to the facility, the resident expressed a desire to stop smoking. A family member requested smoking cessation aids to assist the resident. Documentation in the medical record revealed that during the period of 2/9/03 through 2/24/03 the resident continued to smoke. Documentation was lacking to reflect that the resident was reassessed and/or that the RCP had been revised in response to the identified problems of difficulties with smoking cessation, seizures associated with smoking and/or the need to monitor the resident for smoking. A physician order dated 2/24/03 identified a physician order, which directed the utilization of a nicotine patch. Although the resident was provided with the patch, documentation revealed that she continued to smoke. The RCP had not been revised to reflect the resident's non-compliance with protocols in place for the utilization of the patch. The RCP of 2/26/03 identified problems which included depression and utilization of psychotropic medications. The facility failed to identify specific interventions to address the depression, but instead identified non-specific interventions and approaches which included monitor mental status and behavior, monitor depression, provide individual supportive contacts allowing verbalization of feelings, discourage isolation by encouraging socialization and involvement in TRD activities and psych consult prn. Also identified as a concern or problem was the issue of "independent smoker." The facility failed to identify specific interventions to address this problem as well, but instead identified non-specific interventions and approaches which included review smoking assessment prn, assess patient for signs and symptoms of non-compliance, encourage resident to smoke in designated place, evaluate resident for safe smoking technique prn, smoking apron as needed, provide teaching how to use apron and how to remove appropriately.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

5. Based on review of the clinical record, and interviews with facility personnel for one resident, Resident #123 the facility failed to provide evidence of a comprehensive discharge plan in the clinical record. The findings include.
   a. Resident #123 was admitted to the facility on 7/29/02 with diagnoses inclusive of quadriplegia, substance abuse, antisocial personality, and severe depression. Review of the Minimum Data Set (MDS) dated 2/7/03 identified intact short and long-term memory. Review of the clinical record on 2/27/03 identified that Resident #123 was discharged on 2/26/03 at 9:30 PM to another facility at the request of the resident. Review of the clinical record failed to provide evidence of a physician's order for discharge, or that an interdisciplinary discharge plan was completed. In an interview with LPN #8 on 2/27/03 at 3:30 PM, she stated that she first became aware of the impending discharge of Resident #123 on 2/26/03 at around 8:30 – 9:00 PM when a social worker instructed her to complete the W-10 paperwork. LPN #8 stated that during the evening Resident #123 was in his usual mood and did not communicate psycho-social distress related to the events that had occurred in the facility that day, nor did he indicate that he was being discharged. LPN #8 further stated that when a nurse aide attempted to pack Resident #123's belongings he stated it was not necessary because he was returning to the facility in a few days. Interview on 2/27/03 with the Director of Nurses and/or Administrator identified that all residents were afforded the opportunity to relocate to other facilities after the fire and Resident #123 had previously requested to be discharged to another facility. They further identified that they had previously been unsuccessful in arranging a discharge of the resident to another facility, and that this was the only resident discharged on 2/26/03 that had not resided on the units that were damaged due to the fire.

The above is a violation of the Connecticut General Statutes Section 19a-535 and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (p) Discharge Planning (1).

6. Based on clinical record reviews and interviews for two (2) of two (2) sampled residents, the facility failed to provide care in accordance to the RCP, Resident #1 and R #95.
   a. Resident #1 was admitted to the facility on 2/5/03 with admitting diagnoses of multiple sclerosis and depression. She was also described as having seizures.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Resident #1 had a documented history of burning self deliberately with a cigarette prior to admission. The MDS of 2/15/03 identified that the resident had some impairment in cognitive skills for daily decision making, was angry, sad, cried was unsteady while standing and used a rolling walker for ambulating. A history of a fall within the last thirty days was identified. A physical therapy evaluation dated 2/6/03 identified ataxia in the bilateral lower extremities. An occupational therapy progress note identified that cognition was slow and upper body strength was impaired along with balance. The patient's gross movements were ataxic. The occupational therapy plan for treatment identified that the resident's fine motor coordination was impaired. A smoking evaluation which was undated, identified that the resident was not oriented to place. Rationale was described as "remains candidate" and smoking designation was blank. The RCP of 2/6/03 identified the resident as an independent smoker. Interventions included to review the smoking assessment as needed, assess resident for noncompliance, assess resident's physical capability of receiving information for smoking as well as physical ability to adhere to smoking policy rules, review smoking policy with the resident and consequences of not adhering, acknowledge resident needs to smoke and provide support, encourage resident to smoke in designated areas, evaluate resident for safe smoking as needed, smoking apron as needed, provide teaching how to wear apron and how to remove appropriately. A nursing progress note identified that on 2/9/03, the resident went to the patio for a cigarette and after smoking suffered a grand mal seizure. The resident was transferred to a local hospital where she was evaluated and returned to the nursing home on the same day. Discharge instructions on the interagency transfer document identified the need for monitored smoking breaks and seizure precautions. Documentation in the medical record revealed that during the period of 2/5/03 through 2/25/03 the resident went out to the courtyard to smoke with a friend and/or continued to smoke. Documentation was lacking to reflect that the resident was ever monitored and/or re-assessed for safe smoking techniques following the initial assessment and/or following her transfer to the hospital for evaluation of her seizures. There was no information identified in the medical record, which identified monitored smoking breaks as per the W-10. Documentation was also lacking that the resident had ever been educated relative to the utilization of a smoking apron as per the RCP and/or was provided with an apron.

b. Resident #95 was admitted to the facility on 7/17/02 with diagnoses of congestive heart failure and coronary artery disease. The RCP of 2/21/03

identified a problem of wandering. Interventions included cueing, redirection barriers across rooms which resident enters. A psychiatric consult dated 3/5/03 identified a history of dementia and depression. A review of facility documentation revealed that on 3/4/03 an incident occurred between Resident #95 and Resident #126 due to Resident #95 entering Resident #126's room without permission. The RCP for Resident #95 was revised and dated 3/4/03 and reflected that current interventions were to be continued. Interview with NA on 3/5/03 who was responsible for caring for Resident #95 on 3/5/03 for the 7am-3pm shift revealed that she was not made aware of any special care needs with regards to wandering. A review of the NA assignment did not reveal information relative to re-direction or monitoring of the resident for wandering.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

7. The facility failed to protect residents in that a fire occurred on 2/26/03 which resulted in directly causing the deaths of fifteen (15) residents, and one additional resident who subsequently expired after having suffered from smoke inhalation. The findings are based upon staff interviews, review of facility policies/procedures, review of medical records and include the following:
    a. On 2/26/03 the Department learned of a fire which occurred at the facility. It was reported that several residents had died and numerous residents had been transferred to the hospital. The 11pm - 7am Nursing Supervisor reported that the fire had been caused by Resident #1. Subsequent interviews with facility staff regarding their duties/responsibilities in a fire, it was ascertained that the facility failed to follow their established fire plan on 2/26/03 and that Resident #1 was not appropriately assessed and monitored relative to identified needs. An additional interview conducted with the 11pm-7am nursing supervisor who was on duty during the fire, revealed that she opened the window in the room where the fire occurred and thus increased the oxygen supply in the room.

The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (f) Administrator (3)(A).

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

8. For eleven (11) of eleven (11) sampled residents, who were identified to be smokers, the facility failed to provide adequate supervision. (R #122, R #107, R #87, R #121, R #37, R #114, R #80, R #125, R #13, R #141, R #7). The findings include:
   a. Resident #122 diagnoses included cervical spine disorder, dementia and seizure disorder. The quarterly assessment of 10/10/02 identified long and short term memory problems and that mental function varies over the course of the day. The RCP of 10/02/02 identified the resident as an independent smoker. The smoking evaluation tool dated 4/12/02 identified the resident as needing assistance to light smoking materials and not extinguishing smoking materials safely, sometimes allowing ashes to fall onto clothing with a recommendation for a smoking apron to be worn at all times. The designated area for smoking level was not completed. On 2/26/03, LPN #2 identified Resident #122 as independent in smoking, however, that she gave him his cigarettes and he did not hold his own. Nurses narratives reflected that on 2/27/03 after nurses told Resident #122 that he could no longer keep smoking materials with him he refused to give his lighter and matches to the nurse. The resident's daughter was called to intervene and the smoking materials were given up on 2/27/03. A smoking evaluation dated 2/27/03 identified that the resident was to smoke with supervision on the patio. A smoking assessment dated 3/1/03 was incomplete and failed to reflect the resident's cognition as required by the form, and noted the resident as angry and "states he will smoke when he can and try to obtain cigarettes." Nurses narratives of 3/1/03 identified the resident had cigarettes and lighter and that the daughter was notified. There were no additional narratives regarding the resident's noncompliance with the smoking policy or that the cigarettes were removed or the resident was being monitored. Interview with the charge nurse revealed the resident's daughter took the cigarettes on the 3-11 shift. The NA assignment identified the resident was a smoker, however, revealed no information pertinent to the resident monitoring for non-compliance. Interview with the NA assigned to Resident #122 on 3/6/03 revealed she had not been informed of the incident or that Resident #122 needed to be monitored. On 3/6/03, Resident #122 was observed during the morning smoking time to be on the patio smoking. Resident was observed without a smoking apron, hunched over in his wheelchair with a very short stub of a cigarette held between his fingers.
   b. Resident #107 diagnoses included NIDDM, schizophrenia and a left below the knee amputation. The RCP identified the resident with a cognitive deficit and

unable to express needs. Physician orders reflected the resident as taking multiple psychotropic medications. The smoking assessment dated 4/24/02 to 1/09/03 identified the resident as an independent smoker. LPN #2 on 2/26/03 identified the resident as independent, however, she gave the resident his cigarettes. The RCP did not identify the resident as a smoker until 2/26/03. Goals included handling smoking materials safely and smoking in designated areas only. The smoking assessment of 3/01/02 was incomplete and failed to identify the resident's cognitive deficits. Nurses' narratives of 2/27/03 identified the facility's smoking policy explained and resident surrendered lighter. Narrative of 3/01/03 at 2:00 p.m. identified resident had "cigs on the patio," DNS aware. The resident stated it was his last cigarette. There were no further notes in the record reflecting any monitoring for compliance. LPN #2 stated a visitor had brought in the cigarettes. The NA assignment identified on 3/6/03 only that the resident was a smoker. Interview with NA #10 assigned to Resident #107 on 3/06/03 revealed she had not been informed the resident had been non-compliant with the policy or that she should be monitoring Resident #107 for this. On 3/10/03 during the 1:30 p.m. supervised smoking Resident #107 was observed after receiving his cigarette from the NA to wheel him self to the far end of the patio and smoke with his back to the NA.

c. Resident #87's smoking assessment of 3/1/03 was initially incomplete for cognitive deficits. A revision on 3/7/03 indicated the resident on psychotropic medication with poor safety awareness. The RCP of 2/27/03 was revised to indicate Resident #87 was a supervised smoker. On 3/05/03 Resident #87 was observed during the supervised smoking at 11:45 a.m. on the patio with a group of approximately 15 residents and one staff member in attendance. Resident #87 was seated in a wheelchair with a smoking apron in place and was observed to continually flick her ashes onto her apron. The staff member did not intervene. On 3/10/03 Resident #87 was observed at 1:30 p.m. during supervised smoking. Although the resident had on a smoking apron it failed to be secured as required by the manufacturers directions to attach the loop straps to the sides and lower bars of the wheelchair. The DNS stated on 3/10/03 the facility did not have a policy on the proper application for the apron and stated she would develop one based on the manufacturer's directions.

d. Resident #121 diagnoses included chronic schizophrenia and hypertensive heart disease. The quarterly assessment of 10/31/02 identified moderate cognitive impairment with poor decision abilities, cues and supervision

required. The RCP of 2/6/03 identified the resident problem of hoarding and taking others belongings. On 2/26/03 the resident was identified as a smoker. Interventions included monitoring regularly for safe handling of smoking materials and supply resident with a smoking apron as needed. The smoking assessment of 3/01/03 failed to identify the resident's cognitive deficits and referenced the resident's psychiatric diagnosis and the psych notes. Nurses narratives of 2/27/03 identified smoking materials surrendered to nurse and lighter obtained. Resident weepy and does not show compliance. On 3/11/03 at 6:00 p.m. a narrative describes the resident found with 11 working cigarette lighters, two on her person. Documentation was lacking as to where the resident had obtained the lighters. Interview with the DNS on 3/10/03 at 2:00 pm revealed she was unaware of how or where the lighters had been obtained. The RCP on 3/10/03 failed to be revised to reflect the hoarding of lighters and resident's non compliance with the new smoking policy of 2/27/03. The NA assignment reviewed on 3/10/03 did not provide instructions for monitoring the resident for non compliance. Interview with NA #11 revealed she was unaware of the incident of having 11 cigarette lighters and stated she was not given any instructions regarding monitoring the resident. Observation on 3/10/03 at 1:30 p.m. revealed the resident in a group of 12 residents on the patio. Resident had no smoking apron in place. Resident was seated in a chair with a walker placed in front of her rocking back and forth. Interview with the NA assigned to monitor the residents revealed he had no knowledge of individual needs of the residents and had only been provided with a list of residents who smoke and those requiring an apron.

e. Resident #37's quarterly assessment of 1/16/03 identified the resident with moderate cognitive impairment, poor decision ability, cues and supervision required. The resident received multiple psychotropic medications daily. The RCP of 2/27/03 identified the problem of smoking safely with supervision. Interventions included to smoke in designated area only, supervise resident while smoking at designated times as needed, observe resident while smoking to prevent burning self, others or clothes. The smoking assessment of 3/1/03 failed to address judgment and identified poor insight to how fire affects him or the facility. On 3/10/03, Resident #37 was observed during the group smoking at 1:30 p.m. The NA lit his cigarette and the resident walked to the far end of the smoking area to smoke. The resident's back was to the NA who was still passing and lighting cigarettes for eleven other residents.

f. Resident #114's assessment of 2/19/03 identified no cognitive impairment. The RCP of 2/26/03 identified the resident as a smoker. Interventions

included completing initial assessments, monitoring regularly to ensure handling of smoking materials safely. The smoking assessment of 3/01/03 identified resident demonstrates safety with smoking disposes of ashes properly. Observation on 3/10/03 during the 1:30 p.m. supervised smoking of Resident #114 revealed the resident to throw her cigarette to the ground and grind the cigarette butt with the heel of her cloth slipper. This was immediately brought to the attention of the DNS, who although present had not observed this action by Resident #114 nor had the NA monitoring the supervised smoking.

g. Resident #80's assessment of 12/24/02 identified cognitive skills for daily decisions as poor with cues and supervision required. The RCP of 2/27/03 identified resident was a smoker with supervision. Goals included handling smoking materials safely. Interventions included monitoring the resident to ensure resident handling smoking materials safely. The smoking assessment of 3/01/03 was incomplete and revised on 3/7/03 to reflect resident unable to verbalize smoking rules. Revisions on 3/7/03 identified resident extinguishing cigarettes safely and no issues with safety. On 3/10/03 during the 1:30 p.m. supervised smoking period the resident was observed by the surveyor to pinch the burning end of his cigarette to extinguish. This was brought immediately to the attention of the DNS who was present but had not observed this action. This also was not observed by the NA who was assigned to the smoking area.

h. Resident #125's MDS of 2/20/03 identified severe impairment in the area of cognition. A nursing progress note dated 2/20/03 identified impaired decision making ability. The RCP of 2/26/03 identified a problem of smoking. Interventions included monitor resident regularly, supply resident with smoking apron as needed, and supervise resident's smoking routine as needed. A smoking assessment dated 3/1/03 identified that the resident was aware of the smoking rules, however did not wish to follow them and required close monitoring. Observation of the resident while smoking on 3/10/03 revealed that the resident chose to smoke away from the group and not in close visual proximity of the supervising aide. The resident smoked with his back turned to the aide, which prohibited the aide from being able to visualize the resident's smoking activities. The resident was not wearing a smoking apron. A review of the nurse aide assignment relative to smoking simply identified the resident's name along with his assigned unit and did not reflect any individualized smoking plan. Interview with the DNS on 3/10/03 revealed that the RCP was done prior to the smoking assessment and identified generic interventions, such as smoking apron as needed. Once the smoking assessment

was conducted, individualized interventions were identified however they were not necessarily reflected on the RCP. Further interview identified that there was no other mechanism in place to allow for information from the RCP and/or smoking evaluations to be transmitted to the nurse aide who was responsible for supervision of the smoking activities.

i. Resident #13's MDS of 12/16/02 identified moderate impairment in cognition and behaviors, which consisted of distraction and restlessness. The RCP of 2/27/03 identified a problem with regards to smoking. Interventions included supervision of the resident while smoking, observation of the resident while smoking to prevent burning of self and clothing. A smoking assessment dated 3/1/03 identified cognition deficits with regards to insight, judgment and confusion. On 3/10/03 the resident was observed while smoking. Although an aide was in attendance while the resident was smoking, the resident chose to smoke away from the group and not in close visual proximity of the aide. A review of the nurse aide assignment relative to smoking simply identified the resident's name along with her assigned unit and did not reflect any individualized information such as confusion, poor insight, etc.

j. Resident #141 was admitted to the facility with a multiple medical diagnoses which including peripheral neuropathy, hepatic encephalopathy and depression. The resident was also receiving multiple medications which included Methadone 65 mg orally daily. Morphine Sulfate ER 30 mg tablet SA twice daily, Neurontin 1200 mg twice daily, Wellbutrin SR 150 mg tablet twice daily and Morphine Immediate Release 15 mg tablet every four hours for lung pain. The MDS dated 2/17/02 identified limited to extensive assistance required for ADL's. A smoking assessment dated 3/1/03 identified cognition deficits in the areas of insight, judgment and that the resident required a smoking apron. Poor safety awareness and confusion were described as non applicable (NA). Observation of the resident smoking on 3/10/03 at approximately 1:30 pm revealed that the resident had a smoking apron in place which was draped over her torso, however, not affixed via velcro straps, as per manufacturer's instructions. The resident was observed dropping ashes from her cigarette onto a bath blanket which was draped over her torso as well and which was not covered by the smoking apron. Although a nurse aide and the DNS were in attendance for the purpose of smoking supervision, they did not observe the resident's inappropriate disposal of ashes.

k. Resident #7 was admitted to the facility on 8/26/02. The resident was identified on the Hospital Discharge Summary as having mental status

changes. The smoking assessment dated 3/1/03 identified that the resident did not demonstrate safety with smoking, did not dispose of ashes properly and did not keep cigarettes away from self/clothing or other flammable objects. She was also described as having poor vision and requiring a smoking apron. The RCP of 3/1/03 identified a problem of resident being a smoker. Interventions included the utilization of a smoking apron. Observation of the resident on 3/6/03 identified that the resident was smoking on the patio. An aide was in attendance. Resident #7 was noted with bilateral tremors of both upper extremities. The resident was not observed with a smoking apron in place. Interview with the nurse aide revealed that she was not aware that the resident was supposed to wear a smoking apron. This information was not on the nurse aide assignment nor was there a mechanism in place to alert the aide who was supervising the smoking breaks of the individualized needs of the residents while they were smoking. Interview with the charge nurse who was assigned to care for this resident at approximately 11:00 am on 3/6/03 revealed that she got to work at 7:00 am and immediately started passing medications and did not have time to update the nurse aide assignments.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

9. For one sampled resident with a G-tube, the facility failed to ensure the feeding was administered as ordered, Resident #97. The findings include:
   a. Resident #97 had diagnoses of syncope, Alzheimers Disease and dehydration. Review of the clinical record revealed on 2/6/03 the resident had a peg feeding tube placed. Physician orders of 2/24/02 directed all medication via G-tube, turn tube feed off at 10:00 AM restart at 2:00 PM. Glucerna RTH at 85 cc/hour for 20 hours. On 2/26/03 at 4:40 PM Resident #97 was observed seated in recliner at bedside with G-tube pump alarming. The feeding bag was empty. At 5:10 PM the tube feeding still was not running and the feeding pump alarm was still sounding. The surveyor notified the nurse at this time. The nurse stated initially on 2/26/03 he had cleared the pump and restarted the tube feeding at 2:00 PM. He stated he could not state how much was in the container at the time the feeding was resumed. On 2/27/03, LPN #1 stated he realized after reviewing the medical record that the order of 2/24/03 had not been transcribed onto the kardex. He was not aware of the order. He stated

he did not stop the pump at 10:00 AM and the tube feeding had remained running between 10:00 AM and 2:00 PM.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I).

10. The only sampled resident leaving for a leave of absence, the facility failed to ensure the policy for medications on leave of absence was followed, Resident #98. The findings include:
    a. Resident #98 was observed on 2/26/03 at 5:15 PM being signed out for a leave of absence (LOA) with his mother. LPN #1 was observed pouring medications from bubble cards for a three day supply of medication and labeling individual envelopes. LPN #1 stated the administrator stated resident could go out on leave and he had not called the MD for permission for this LOA. The clinical record was reviewed at 5:15 PM and revealed Resident #98 had diagnoses of NIDDM and obesity. Resident #98 had orders for multiple psychoactive medications and a physician order, may go on LOA overnight. There was no order for a three day leave. The facility's policy for "out on pass" medications directs that nurses are allowed to provide only one dose of each drug needed for the duration. The policy directs the charge nurse to review medication orders and directions with the physician. All medications provided are properly labeled in appropriate containers. At least 24 hours notice is given to the pharmacy. Interview with the Administrator on 2/27/03 revealed she took an order from the physician and documented it in the record "as a nurse" and she did not document the order at the time it was obtained.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(G).

11. Based on observations and interview, the facility failed to ensure the safe storage of medications.
    a. Observations on 3/10/03 at 1:15 pm and at 2-2:15 pm revealed the door to the DNS office open and the office unattended. Five stacks of multiple blister pack medications were observed stacked on the table in the room. A large plastic bag was observed on the floor filled with resident medication cards. Two medication carts were also in the room with 5 bottles of solution noted

on top of the carts. Interview with the DNS at 3:00 pm identified she was aware of the need to keep the medications locked when unattended.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or Section 19-13-D8v (b) (4)(C).

12. Based on staff interviews, review of policies and facility documentation, the facility failed to be administered to attain the highest practicable physical mental and psychosocial well being of each resident. The Administrator failed to ensure facility policies and procedures were current and implemented as evidenced by the following:
    a. Three residents transferred to hospitals lacked a visible form of identification on their person and were listed as Jane Doe and/or X-2, X-3. One resident who expired in the facility lacked visible form of identification for confirmation of identify.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (d) General Conditions (3)(A) and/or (e) Governing Body (1)(B) and/or (f) Administrator (3).

13. On 2/26/03 a fire occurred in the facility on the 11-7 shift. The facility's staff failed to conduct fire drills on the 11-7 shift as evidenced by the following:
    a. The fire drills conducted on the 11-7 shift consisted of a review of procedures by the supervisor and the sign off of a form. Not all areas on the form were checked off as completed.
    b. Review of fire drill documentation indicated staff did not participate in an actual drill and interviews confirm staff did not routinely go through the entire procedure of clearing hallways, closing doors etc.
    c. Interviews with staff conducted after the fire on 2/26/03 confirmed that the float staff from station 5, 7 and 8 did not respond to assist in containment and evacuation of 33 residents on the affected unit. The float aide did not respond per policy with a fire extinguisher to the lobby for direction. Staff placed dry blankets at the base of the smoker barrier doors instead of wet blankets indicated in the plan.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (f) Administrator (3)(A).

DATES OF VISIT: February 26, 27, 28, March 1, 5, 6, 10 and May 9, 2003.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

14. The facility's Smoking Policy from the safety manual on each of the nursing units identified that residents would not carry smoking materials. This was in direct conflict with the facility's smoking policy and practice in place at the time of the fire that allowed residents designated as independent to carry their own lighters and cigarettes.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3).

15. The DNS failed to ensure resident safety and failed to implement a mechanism to incorporate the resident smoking assessments into the Resident Care Plan that ensured the information was provided to the NAs via the nurse aide assignments as evidenced by:
    a. The supervision and implementation of the revised smoking policies was inadequate as evidenced by the following:
        i. Observation on 3/14/03 during the supervised smoking at 8:45am revealed NA #12 failed to have a copy of the current resident information that identified the resident's smoking needs/problems
        ii. NA #12 was observed lighting cigarettes and passing out one and two cigarettes at a time for nine residents. NA #12 failed to observe R #114 brush against and knock off the burning end of R #7's cigarette with her arm.
        iii. R #86 was wearing R #7's smoking apron that was not secured per the manufacturers directions to the frame of the wheelchair. R #86 continually flicked her ashes into the apron.
        iv. R #138's smoking apron also was not applied as specified by the manufacturer.
        v. NA #12 left the residents unattended when he left the smoking area, went inside to obtain assistance when R #7 became ill and a mechanism to call for assistance was lacking. NA #12 was gone for approximately 2-3 minutes.
        vi. NA # 12 upon interview stated the only residents he needed to watch were R #7, R #86 and R #133 as the others "do okay."
        vii. NA #12 failed to observe R #121 take a drag from R# 128's cigarette, given to R #121 to discard in the ash tray.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

16. The supervision and implementation of the facility's policy for identification of residents was lacking as evidenced by the following:
    a. Tours of the facility on 5/9/03 revealed that ten residents were lacking a visible form of identification on their person and/ or a photograph as an alternate method of identification. (R #19, # 47, # 63, #77, # 79, # 80, # 81, #83, #99, #107). Interview with facility staff identified the photographs were used as an alternate form of identification for residents who were not willing or unable to wear a bracelet. The photographs were "in the process of being developed". Staff also checked for identification on a weekly basis.
    b. Subsequent to the questions of the surveyor the facility implemented an immediate plan for photographs to be maintained on all residents as an alternate and that the checking of the wrist band identifications would be conducted and documented on each shift.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (d) General Conditions (3)(A) and/or (e) Governing Body (1)(B) and/or (f) Administrator (3).

17. On 5/09/03 two posted evacuation plans on unit 5 and unit 7 continued to incorrectly reflect the area where they were posted.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3).

18. The administrator and DNS failed to completely investigate the circumstances of the fire of 2/26/03 as evidenced by the following:
    a. On 5/9/03, the surveyor requested the facility's documentation regarding events of the fire. Although the DNS stated the interviews were concluded on 4/9/03, a summary and conclusion were not available and was formulated the morning of 5/9/03 and given verbally to the surveyor. The determination was that staff acted appropriately.
    b. Interviews of staff failed to reflect all questions asked and lacked times and sequences of events.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

c. The DNS failed to document an interview with the 11-7 supervisor and lacked an interview with NA #1. The DNS stated although some interviews reflected conflicting statements, she pursued these conflicts, however, had not documented the questions or her rationale that staff acted appropriately. None of the questions on the statement obtained from staff reflected queries regarding the behavior of Resident #1 or identified as the cause of the fire.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3).

19. Based on record review, observation and interview for 44 of 128 residents, the facility failed to provide a means of identifying residents. The findings include:
    a. During a tour of the building on 2/26/03 at 8:00 AM, observations identified the following residents from Unit 5 lacked a visible form of identification: Resident (R) #65, R #66, R #69, R #70, R #75, R #76, R #77, R #80, R #81, R #85, R #86, R #87, R #89, R #90, R #91, R #92, R #93 and R #95.
    b. During tour on 2/26/03 at 8:00 am on Unit 7 the following residents lacked a visible form of identification: R #99, R #100, R #103, R #106, R #107, R #109, R #113, R #115, R #118, R #120, R #121, R #122, R #124, R #125, R #126, R #127, R #129, R #130 and R #131. In addition the following residents names were not identified outside the resident's room and/or was illegible: R #78, R #91, R #95, R #98.
    c. During a tour on 2/26/03 at 8:00 am the following six residents were eating in the dining area without a visible form of identification: R #27, R #32, R #78, R #98, R #114 and R #125. R #9 had no visible form of identification on his person, but had his name on his leg prosthesis. Interview on 2/26/03 with the staff development coordinator identified that other than name bands there was no system in place to identify residents. The lack of identification was conveyed to the Administrative Staff.
    d. During a tour of the facility on 2/27/03 at approximately 10:00 am the following residents were found to still lack a visible form of identification: R #70, R #80, R #87, R #99, R #103, R #109, R #113, R #115, R #121, R #122, R #125, R #126, R #127, R #127, R #129, R #130 and R #131. In addition the following residents names were not identified outside the resident's room and/or were illegible: R #78, R #95, R #98, R #91, R #107, R #113, R #114, R #126 and R #129.
    e. On 2/27/03 at 10:00 am, R #128 was observed seated in the dining room and was wearing a name band that was illegible.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

f. On 5/09/03 10 residents were observed to still lack a visible form of identification and or lacked photograph identification.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (d) General Conditions (3)(A) and/or (e) Governing Body (1)(B) and/or (f) Administrator (3).

20. Based on documentation review and interview with twelve (12) of twelve (12) staff working the 11 pm to 7 am shift on February 26, 2003 and additional staff, the staff in other units failed to respond as required in the Facility Fire Safety Plan. The findings include:
    a. During a fire and consequent alarm on February 26, 2003 at Greenwood Health Center at approximately 2:30 AM, the facility staff failed to respond as stated in the Facility Fire Response Plan (11-7..., Float Aide will report to the lobby with a fire extinguisher to assist at fire location. If there is no Float Aide, the Station 8 Aide will respond.). The findings include:
    b. Staff interviews indicated that staff responded as follows:
        i. RN # 3-(supervisor) responded to fire area from Unit 8 area;
        ii. LPN # 5 -(charge nurse) remained on Unit 8 and did not assign a NA to respond with an extinguisher to the lobby area;
        iii. NA # 7 - remained on Unit 8;
        iv. NA # 8 - remained on Unit 8;
        v. LPN # 3 - (charge nurse) remained on unit 5 / 7 and did not assign a NA to respond with an extinguisher to the lobby area ;
        vi. NA # 1 - remained on Unit 5;
        vii. NA # 3 - remained on Unit 7;
        viii. NA # 2 - remained on Unit 5 / 7, until she responded to Unit 8 to help receive evacuees;
    c. Based on staff interviews, approximately 10 to 15 minutes into the incident, staff on Units 5, 7 and 8 did not know what had caused the fire alarm to sound and that there was an actual fire. Staff stated that an NA is supposed to take a fire extinguisher from the unit and head to a central location and wait for further instructions.
    d. Document review (test questions from previous and present inservices) and observation for a staff in-service on the fire safety program held on 2/27/03 at 3:15 PM, indicated that "One CNA from each wing must immediately grab an extinguisher and go to the break room as quickly as possible and that all drills

are treated as fire alarms." The instructor also repeatedly stressed this statement.

21. The facility failed to properly conduct fire drills on the 11 pm to 7 am shift as required in NFPA 101 "Life Safety Code", section 31-4.1.3. The findings include:
    a. Based on documentation review and staff interviews, third shift drills consisted of a "paper review" and not an actual alarm (or coded announcement) and drill to "...familiarize facility personnel with signals and emergency actions required under varied conditions...the purpose of a fire drill is to test the efficiency, knowledge, and response of institutional personnel." Staff interviews indicated the following:
        i. LPN #4, LPN #5, NA #1, NA#2, NA #3, NA #4, NA# 5 and NA #6 stated that third shift drills were conducted by reviewing drill procedures through questions and reviewing assignments during drills

22. Based on clinical record review, observation and staff and resident interviews, the facility failed to comply with smoking regulations in that the facility allowed smoking by patients classified as not responsible to smoke and keep lighting materials without direct supervision. The findings include:
    a. The smoking policy from the safety manual available on all units was in direct conflict with practice and policy of facility, stating "...residents at no time to hold lighting materials in there possession..". Smoking policy and practice of the facility in place on 02/26/03 allowed residents classified as independent to carry own lighting materials.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).